MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10321 — Reg. Dist. No. 10295

M

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ACCIDENT
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL ACCIDENT
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	WILLIAM	FAZENBAKER	SEPT	23	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W		MAY 14, 1879	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABOR	RETIRED	ACCIDENT, GARRETT Co. Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN T. FAZENBAKER	SUSAN BITTINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
		John Henry Fazenbaker, Accident, Md

I

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypochromic Anemia — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Feb. 25-'60, to Sept. 23, 1960, that I last saw the deceased alive on August 6, 1960, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. L. Baumgartner, M.D. — ADDRESS (Street, city or town, state): 25 ALDER ST OAKLAND MD — DATE SIGNED: 9/24/60

PHYSICIAN'S NAME (Type): E. L. BAUMGARTNER

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	9/25/60	BETHESDA	RURAL GRANTSVILLE GARRETT Co MD

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Don J. Newman	Grantsville, Md.	SEP 28 '60	Charles S. Kuna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

CERTIFICATE OF DEATH

Reg. Dist. No. 10296

1. PLACE OF DEATH
a. COUNTY: Garrett County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Oak Rest Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY: Preston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kingwood
d. STREET ADDRESS: 85 X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cora — Middle Sanders — Last McCabe

4. DATE OF DEATH: Month September — Day 14, — Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 1, 1884
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months 8 — Days 13 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New E ast White Haven, Penna.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lemuel E. Sanders
14. MOTHER'S MAIDEN NAME: Mary Bean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edna Osborne — Address: Kingwood, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uterus Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/29, 1958, to 9/14/60, 19____, that I last saw the deceased alive on 8/29, 1960, and that death occurred at 9:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. E. Mance M.D. — ADDRESS (Street, city or town, state): 101 Third Street — DATE SIGNED:

PHYSICIAN'S NAME (Type): A.E.Mance, M.D. — Oakland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/17/60
22c. NAME OF CEMETERY OR CREMATORY: Maplewood Cemetery
22d. LOCATION (City, town, or county) (State): Kingwood, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Irma June Kigel Williams — ADDRESS: Kingwood, W. Va.
24a. REC'D BY REGISTRAR DATE: SEP 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10316

CERTIFICATE OF DEATH

Reg. Dist. No. 10297

1. PLACE OF DEATH
a. COUNTY Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oak Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE West Virginia — b. COUNTY Preston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pisgah
d. STREET ADDRESS: 85X3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cora — Middle Blanche — Last Ormand

4. DATE OF DEATH: Month Sept. — Day 12, — Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December 26, 1873
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pisgah, West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wilmer Collins
14. MOTHER'S MAIDEN NAME: Harriett Metheny

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT Address: Marchall Zweyers, Terra Alta, West Virginia.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial infarction, acute	1 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. DUE TO (b)	Auricular fibrillation	Years
DUE TO (c)	Arteriosclerotic cardiovascular disease	Years

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthritis. Stasis ulcer of right ankle.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-12-60 A.M. 19____, to 9-12-60 P.M 19___, that I last saw the deceased alive on 9-12-60, 19____, and that death occurred at 11:50 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Feaster Jr. M.D.
ADDRESS (Street, city or town, state): Oakland, Maryland.
DATE SIGNED: 9-15-60
PHYSICIAN'S NAME (Type): JAMES H. FEASTER, JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial
22b. DATE THEREOF: 9/15/60
22c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery,
22d. LOCATION (City, town, or county) (State): near Pisgah, West Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Terra Alta, West Virginia
Md' F D License A8305

24a. REC'D BY REGISTRAR DATE SEP 19 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuhns

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
TSM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10317

CERTIFICATE OF DEATH

10298

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 37 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cuppett Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 10 So. Allegany Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Annie — Middle: Barbara — Last: Porter

4. DATE OF DEATH: Month: 9 — Day: 16 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 2, 1870

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Morantown, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Engle

14. MOTHER'S MAIDEN NAME: Catherine Bittner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Patients Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

DUE TO (b): Arterio-sclerosis - Advanced — Unknown

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 13, 1957 to Sept 16, 1960 that I last saw the deceased alive on Sept 16, 1960, and that death occurred at 7:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, State): 77 Oak St Oakland, Md. — DATE SIGNED: 17 Sept 60

PHYSICIAN'S NAME (Type): Herbert H. Leighton, 77 Oak Street, Oakland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/19/60

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 20 '60

24b. REGISTRAR'S SIGNATURE: Irvin S. Kaufman

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fune... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10299

Item 7 Film C271 9-26-60 et

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Deer Park, Md.
c. LENGTH OF STAY IN 1b: Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Alleg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 225 Wood St., Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alvin; Middle: Luther; Last: Roderick

4. DATE OF DEATH: Month: Sept.; Day: 18th; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 22, 1932

9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Steel Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME: Carl L. Roderick

14. MOTHER'S MAIDEN NAME: Edna Sollars

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): Yes 1953-1955

16. SOCIAL SECURITY NO.: 212-32-8041

17. INFORMANT: Address: Mrs. Edna Roderick Westernport, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SHOCK; THORACIC & ABDOMINAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 10 Min.
825x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CRUSHED CHEST; ruptured SPLEEN, LIVER — 10 Min.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident Rt. 135& R. 495, Nr. Deer Park, Md.
20c. TIME OF INJURY Hour a.m. Month, Day, Year: 2:15 p.m. 9-18 1960
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Rural Deer Park Garr., Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James H. Feaster Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9-18-60
EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D.
Address (Street, city, town, or county): Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/21/60
22c. NAME OF CEMETERY OR CREMATORY: Kalbaugh Cem.
22d. LOCATION (City, town, or country) (State): Elkgarden W.Va.

23. FUNERAL DIRECTOR: E. L. Beal
ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE: SEP 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10310

1. PLACE OF DEATH
a. COUNTY: Garrett
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland, Md.
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garrett Co., Memorial Hosp. Oakland Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Accident, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EDDIE Middle RAY Last STANTON

4. DATE OF DEATH: Month Sept. Day 3 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Oct, 21, 1944

9. AGE (In years last birthday): 15 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours M'n

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Northern High

11. BIRTHPLACE (State or foreign country): Jennings, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Stanton

14. MOTHER'S MAIDEN NAME: Mable Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Edward Stanton, Accident, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY HEMORRHAGE (ASPHYXIATION) — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) GUNSHOT WOUND, LEFT LUNG — "
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): OWN GUN DISCHARGED, MISSLE GOING THROUGH LUNG.

20c. TIME OF INJURY Hour 10:30 p.m. Month, Day, Year Sept.1 19 60

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): ACCIDENT, GARRETT, MD.

21. I certify that I took charge of the remains described above, held an Autopsy [X]. Inspection [X]. Inquiry [X]. and in my opinion death resulted from: Natural causes [ ]. Accident [X]. Suicide [ ]. Homicide [ ]. Undetermined manner [ ]

ACTUAL SIGNATURE: James H. Feaster Jr. M.D. M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [X] Oakland, Md. 9/3/60

EXAMINER'S NAME (Type): JAMES H. FEASTER, Jr. M.D.

Address (Street, city, town, or county):

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/5/60

22c. NAME OF CEMETERY OR CREMATORY: Bittinger

22d. LOCATION (City, town, or country) (State): Bittinger, Garrett Co., Md.

23. FUNERAL DIRECTOR: Don J. Newman

ADDRESS: Grantsville, Md.

24a. REC'D BY REGISTRAR DATE SEP 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

G 10323 — Reg. Dist. No. 11414

1. PLACE OF DEATH — a. COUNTY: Garrett County — a. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville MD — c. LENGTH OF STAY IN 1b: all of life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) — a. STATE: Friendsville — b. COUNTY: Garrett Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oda — Middle: Belle — Last: Thomas
4. DATE OF DEATH: Month: Sep — Day: 28 — Year: 1960

5. SEX: FEMALE — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: April 30, 1876 — 9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house Keeper — 10b. KIND OF BUSINESS OR INDUSTRY: HOUSE WIFE — 11. BIRTHPLACE (State or foreign country): Friendsville MD — 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Elga Thomas Friendsville — 14. MOTHER'S MAIDEN NAME: Barbara Frazee Friendsville

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Apoplexy — "Stroke" — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO (b): Cerebral Arteriosclerosis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension — 36 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Arthritis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): no Injury

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 1960 to Sept 28, 1960 that I last saw the deceased alive on Sept 27, 1960, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin M. Price M.D. — ADDRESS (Street, city or town, state): 612 Logan Place Confluence Pa — DATE SIGNED:

PHYSICIAN'S NAME (Type): Edwin M. Price, M.D. Confluence, Pa.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct 1960 — 22c. NAME OF CEMETERY OR CREMATORY: Sand Spring — 22d. LOCATION (City, town, or county) (State): Friendsville MD

23. FUNERAL DIRECTOR'S SIGNATURE: C. Howard Brandon — ADDRESS: Oakland Md. — 24a. REC'D BY REGISTRAR DATE: OCT 14 '60 — 24b. REGISTRAR'S SIGNATURE: Cullen S. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10319 10301

1 PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
d STREET ADDRESS: THIRD STREET
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EFFA Middle JEANETTE Last THRASHER
4. DATE OF DEATH: Month SEPTEMBER Day 16 Year 1960

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 23, 1877
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): shop keeper
10b KIND OF BUSINESS OR INDUSTRY: GIFT SHOP
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUGHRIDGE, GEORGE
14. MOTHER'S MAIDEN NAME: STEMPLE, MARTHA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-34-1239A
17. INFORMANT: Address: MRS. GROVER STEMPLE, OAKLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 Days
4.22.1
DUE TO (b): Arteriosclerotic Cardio-vascular Dis — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Arteriosclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from ____ 19 48 to Sept. 16, 1960, that (I) (we) last saw the deceased alive on Sept. 15 19 60, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

22a SIGNATURE: Andrew E. Mance M D
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 16 Sept 60
22c PHYSICIAN'S NAME (Type): Andrew E. Mance, M.D.
22d. ADDRESS: OAKLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/18/1960
23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
23d LOCATION (City, town, or county) (State): Oakland, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: H. Leighton
ADDRESS: Oakland, Md.
25a REC'D BY REGISTRAR DATE: SEP 19 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kinnard

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10320

CERTIFICATE OF DEATH

10302

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
d. STREET ADDRESS: 78 OAK STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ANN — Last: TROWBRIDGE

4. DATE OF DEATH: Month: SEPTEMBER — Day: 30 — Year: 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 21, 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM FRANKLIN STEWART

14. MOTHER'S MAIDEN NAME: HELEN MELISSA LERAW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-01-5558

17. INFORMANT: HOMER B TROWBRIDGE, 78 OAK ST., OAKLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cerebro-Vascular Dis — 8 years
DUE TO (c): Arteriosclerosis — 10yrs

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____ 19___ to _____ 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 10:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Andrew E. Mance M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/6/60

22c. PHYSICIAN'S NAME (Type): DR. ANDREW E. MANCE M.D.

22d. ADDRESS: OAKLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10/3/60

23c. NAME OF CEMETERY OR CREMATORY: Kalbaugh Cemetery

23d. LOCATION (City, town, or county) (State): Elk Garden, Mineral Co. W.Va

24. FUNERAL DIRECTOR'S SIGNATURE: Amy M. Shaffer

ADDRESS: Blaine, W.Va.

25a. REC'D BY REGISTRAR DATE: OCT 5 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10303

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Garrett — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crellin
   c. LENGTH OF STAY IN 1b: years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Garrett
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crellin
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Abraham — Middle: Rudolph — Last: Wilson

4. DATE OF DEATH: Month: 9 — Day: 5 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/3/1882

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic

10b. KIND OF BUSINESS OR INDUSTRY: County Rds. Dept.

11. BIRTHPLACE (State or foreign country): Oakland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stephen Wilson

14. MOTHER'S MAIDEN NAME: Virginia Fulmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: Samuel Wilson — Crellin, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Myocardial insuffiency — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James H. Feaster Jr M.D.

EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Oakland, Md.

DATE SIGNED: 9-7-60

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 9/8/1960

22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery

22d. LOCATION (City, town, or country) (State): Oakland, Maryland

23. FUNERAL DIRECTOR: Gerald N. Minnich — ADDRESS: Oakland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 13 '60

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans